BLOOM OB/GYN

Notice of Privacy Practices
Acknowledgement of Receipt

Patient's Name: _____ DOB: _____

I have a received a copy of the Notice of Privacy Practices provided by Bloom Ob Gyn, LLC and understand that the Notice describes how my medical information may be used and how access to this information may be obtained. I have also been given an opportunity to ask questions about the information provided in the Notice.

_____
Signature

_____
Date

_____
Relationship to Patient
(If Acknowledgement Form executed by someone other than Patient)

BLOOM OB/GYN

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. This Notice describes how we protect your health information and what rights you have regarding it.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

Your PHI may be used and disclosed by your physician, our office and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the practice, and any other use required by law.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. Examples of how we use or disclose your health information for treatment purposes include setting up an appointment for you and obtaining copies of your health information from another health care provider that you may have seen before us.

Your PHI will be used to obtain payment for your health care services. Examples of how we use or disclose your health information for payment purposes include obtaining information from you about your health insurance plan(s) or other sources of payment, preparing and sending claims and bills, and collecting outstanding amounts due.

We may use or disclose your PHI in order to support the business activities of our practice. These activities include quality assessment activities, financial or billing audits, personnel decisions, participation in managed care plans, and defense of legal matters.

USES AND DISCLOSURE FOR OTHER REASONS WITHOUT PERMISSION

We may use or disclose your PHI in certain situations. Examples include the following:

- Treatment
- Payment for services
- Healthcare operations
- Public health, legal, or governmental authority
- Friends or family members who you authorize us to communicate
- Workers' Compensation

We may contact you for information to support your health care, including appointment reminders. We may also call or write to notify you of other treatments or services available at our office that may be of

interest to you. We will routinely contact patients via telephone at home and, unless otherwise requested, may leave you a message regarding appointments or leave a message with someone who answers your phone if you are not home. Please advise us if you do not wish to receive such communications.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information without your consent and authorization. You will have the opportunity to object, unless required by law.

REVOCATION

Revocations must be in writing to the Compliance Officer at our practice.

YOUR RIGHTS

You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect information compiled to reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, or PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or health care operations. You may request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes, as described in this Notice. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to a restriction that you may request. If we believe it is in your best interest to permit the use and disclosure of PHI, it will not be restricted. Under such circumstances, where practical, you will be given the opportunity to object to any such disclosure, and you have the right to use another health care provider.

You have the right to request confidential communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You have the right to obtain a paper copy of this notice from us, upon request. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

You have the right to an accounting of disclosures we have made. The accounting of disclosures would not include disclosures made for purposes of treatment, payment, and health care operations or those that were made in response to a specific authorization from you. Your request must be in writing and must state the time period for which you want the accounting (not longer than six years).

You have the right to request an amendment to your PHI. If we deny your request for an amendment, you have the right to file a statement of disagreement with us, and we may prepare a response to your statement and provide you with a copy.

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. All complaints must be in writing. We will not retaliate against you for filing a complaint.